Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-361-2930

Legionellosis

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Fever** Highest measured temp (^{o}F): _____ ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	**Cough** Onset date: ___/___/___
☐	☐	☐	☐	Nonproductive cough
☐	☐	☐	☐	**Muscle aches or pain (myalgia)**

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Chronic liver disease
☐	☐	☐	☐	Immunosuppressive therapy or disease
☐	☐	☐	☐	Chronic diabetes
☐	☐	☐	☐	Chronic lung disease
☐	☐	☐	☐	Smokes tobacco

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Pneumonia or pneumonitis** X-ray confirmed: ☐**Y** ☐**N** ☐**DK** ☐**NA**
☐	☐	☐	☐	Pontiac fever
☐	☐	☐	☐	Admitted to intensive care unit
☐	☐	☐	☐	Mechanical ventilation or intubation required during hospitalization

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**Legionella isolation (normally sterile fluids - respiratory secretions, lung tissue, pleural fluid, etc)** Species: _____
☐	☐	☐	☐	***L. pneumophila*** **serogroup 1 antigen demonstration by radioimmunoassay or enzyme-linked immunosorbent assay (urine)**
☐	☐	☐	☐	***L. pneumophila*** **serogroup 1 detection by DFA (respiratory secretions, lung tissue, pleural fluid)**
☐	☐	☐	☐	***L. pneumophila*** **titer with => 4-fold rise in the reciprocal immunofluorescence antibody (IFA) titer to =>128 against Legionella pneumophila serogroup 1 (paired acute- and convalescent-phase serum specimens**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to figure probable exposure period

	Exposure period		onset
Days from onset:	-10	-2	
Calendar dates:			

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____

☐ ☐ ☐ ☐ Patient hospitalized >48 hours before illness onset
days before onset: _____

☐ ☐ ☐ ☐ Work or volunteer in health care setting during exposure period
Facility name: _____

☐ ☐ ☐ ☐ Visited health care setting during exposure period
Facility name: _____
Number of visits: _____
Dates of visits: _____

☐ ☐ ☐ ☐ Travel or overnight stay other than residence
Specify where: _____

☐ ☐ ☐ ☐ Aerosolized water (e.g. fountains, spas, humidifier, hot tub)

☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)

☐ ☐ ☐ ☐ Soil exposure (e.g. gardening, potting soil, construction

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS/TREATMENT

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Nosocomial infection suspected

☐ ☐ ☐ ☐ Visited health care setting during exposure period
Facility name: _____
Number of visits: _____
Date(s) of visit(s): _____

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Facility notified
☐ Facility inspection

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

Legionellosis: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered